

Ad hoc teams and telemedicine during COVID-19

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ABSTRACT

The pandemic has required creative and agile teamwork and leadership. Creativity was especially necessary when employing the social distancing requirements for this disease. To ensure compliance while also meeting the needs of our system and community, a huge telemedicine initiative was deployed. Administrative leadership utilized ad hoc teams to overcome challenges and ensured success with a shared vision, clarity, communication, and a positive culture. This article outlines how the team was developed, what challenges the team faced, and how they were successful in the uncharted waters of a COVID-19 response. Finally, best practices are shared for inconsistent teams in an inconsistent setting, ensuring success within an ad hoc team residing in a fluid environment.

KEYWORDS Ad hoc teams; COVID-19; leadership; teams; telemedicine

Historically, medicine has both grown and progressed amidst crisis. The pandemic of COVID-19 was no different, in that it required preparedness and innovative responses and solutions to patient care.¹ With distancing requirements to reduce spread, Baylor Scott & White Health (BSWH) needed to build a geographically dispersed and unprecedented telemedicine response. Building this response required ad hoc teams or teaming, which have proven successful in fast-paced environments that require flexibility.^{2,3} Ad hoc teams successfully rolled out a massive telemedicine response, screening over 175,000 patients for COVID-19 and completing over 53,000 e-visits (online adaptive clinical interviews) within the first few weeks. This was an increase from the standard 150 e-visits per day to 1500 to 6000 per day. The team had to quickly evolve and change to serve 10 times the anticipated number of e-visits. This article discusses key aspects of preparation and development, as well as challenges and efforts to ensure success with an ad hoc team.

TEAM DEVELOPMENT

In building the telemedicine response ad hoc team, some key elements were reviewed, including team objectives and goals, team makeup or demographics, and team logistics or

dynamics. Overall, team objectives included limiting traffic to facilities to reduce emergency room overload and exposure to employees and the public, which meant patients' needs would be met virtually. Another objective was to preserve resources such as personal protective equipment (PPE) and testing, as there was uncertainty about supplies at the beginning of the response. Finally and most importantly, the teams wanted to reduce fear through meeting patient needs and keeping up with patient demands.

Each of the identified objectives was considered in compiling the team, because collaboration of essential team members was key for teaming success.⁴ A large part of the initial team consisted of furloughed volunteers and providers with diverse training and specialties, with a heavy emphasis on specialties such as family medicine, internal medicine, and emergency medicine augmented with other specialists who volunteered and were trained. In addition to the large volunteer pool, there was a dedicated telemedicine cohort of providers who were able to assist others and lead in acclimation to this new normal. Team members' specific aim was to help with care demand and reduce the backlog that occurred during the initial COVID-19 public rush for information.

Once volunteers were on board, logistics were quickly addressed. Logistics included team size, team allocation, appropriate volunteers for hours and shifts, workflows and

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protocols, training on both technology and protocols, guidance on testing, and resources. One of the most important preparedness and logistical components that cannot be underestimated was that of communication channels and allowances; with whom and where to communicate were clearly outlined, as well as reduction in hierarchy of communication requirements. Poor communication can affect team outcomes as well as patient outcomes, and having fluid teams makes transparency and clarity even more important.^{5,6} The team essentially became a group of experts and professionals who were able to share openly and directly as each expected or unexpected scenario played out. Most importantly, these ad hoc teams were brought together with a shared mission and vision and quickly began teaming.

CHALLENGES

Some of the biggest hurdles the ad hoc teams faced were misinformation in the media/community, management of patient expectations, evolving scientific guidelines, and patient volume. The misinformation included testing for detection of SARS CoV-2, disease presentation, and treatment. Early on, social media perpetuated misinformation about the pandemic, patient care, and provider response. Misinformation from political leaders also led to frustrated patients who expected to be tested if they requested a test. There were instances of patients setting up additional visits hoping to get a test from a different provider. Ultimately, misinformation led to faulty expectations of the health system and providers, including an expectation of free testing. Rapidly evolving scientific guidelines and protocols also contributed to confusion and frustration, as testing yielded different turnaround times depending on where the patient was tested (internal vs external lab) and testing protocols changed based on supply or updated evidence. Within the first 2½ weeks, BSWH screened 110,769 patients for COVID and completed 30,909 e-visits. In the first 3 months of response, the telemedicine team conducted over 58,000 e-visits with over 26,000 new patients to the system. This volume required teams to work around the clock, making ad hoc teams a necessity. With misinformation, fear, faulty expectations, and evolving science, the ad hoc team members were fighting negative assumptions and attitudes brought to appointments by patients and community members. Therefore, it was more crucial than ever for the teams to operate in a collaborative and seamless way to build trust that may have been broken due to these hurdles.

TEAM SUCCESS FACTORS

To ensure success of these ad hoc telemedicine teams during the COVID-19 response, several best practices were used, including a shared belief in the mission, participation in huddles, clarity and fluidity of messaging, mindfulness of the positive-to-negative communication ratio, and use of appropriate leadership styles. These four practices are

highlighted in the literature as ways to ensure effective teams and effective functioning of ad hoc teams.²

Shared belief in the mission accompanied by attainable goals ensured the team did not fall victim to inattention to results—one of Lencioni's team dysfunctions—as the team had a new shared vision, which minimized individual or departmental goals and egos.⁷ Instead, the groups worked together to meet needs and deliver quality care as well as reduce visit backlogs. To create a team culture of accountability, incremental clear goals were developed and posted.⁷ The shared belief, along with accountability and goals, allowed participants to build stronger buy-in as all team members were essential and recognition did not include hierarchy.

Clarity and fluidity of language and messaging are important for teams who are not familiar with each other. Building in communication expectations can also build trust in the team, which is an important characteristic that can be lacking in a team without shared experiences⁸; teams with trust have better patient outcomes.⁹ With this information in mind, the telemedicine team did several things. First, communication expectations were clearly articulated across dispersed campuses through the Microsoft Teams platform. Through this platform, team members were able to communicate information in real time within three categories on three distinct channels: updates and changes; questions and answers, which included real-time chats with all team members to get instant answers as needed; and referral for testing, which gave specific information about the hand-off from the clinician making the referral over to administration support, who would connect with each specimen collection site to inform them in advance about the patient's arrival. Often handoff is a place where ad hoc teams drop information or lose momentum,¹⁰ but this team ensured there was a protocol for all areas of communication, including patient handoff.

Finally, participating in huddles has become a popular way to quickly get the team on the same page. When properly used, it can be effective and efficient.¹¹ Multiple huddles served this group both in person and virtually. Daily virtual huddles were held in the Microsoft Teams platform, with the primary goal of passing along up-to-date information to all team members.

Team leaders exhibited mindfulness of building a culture of positivity by ensuring a high positive-to-negative ratio within team communications. When patients are scared or fearful, which a pandemic can rightfully create, they can outwardly exhibit negative emotions toward the telemedicine team. Team members were experiencing negative and threatening comments from patients, so team leaders had to ensure there was ongoing support and coaching in how to diffuse hostility or frustration. Ensuring positivity in dialogue, especially in feedback conversations, requires more positive than negative comments.¹² If enough positive capital is built in a relationship, then negative feedback is better received. In

addition to the positive-negative ratio is the phenomenon of emotional contagion, in which emotions pass through groups like a contagion. Positive emotions can minimize conflict and have a positive effect on a group, while negative emotions can do the opposite.¹³ With that in mind, this ad hoc team recognized the essential nature of positivity because the days were long and the stress was high. Focusing on the positive and the mission encouraged team members to support each other, continually checking on morale and making an effort to lift each other with their words.

Utilizing situational leadership, leadership that changes and evolves with the situation, was imperative throughout this telemedicine initiative. All levels of leadership had to change plans and pivot by the hour. As availability of resources, information about COVID-19, and institutional protocols changed, so did administrative leadership and local team leadership. These changes and evolutions required leaders to be quick on their feet, nimble and adaptable to changing directions. Each new day came with a new problem to solve, which required creative leadership willing to switch directions and plans as needed. To ensure mobility, decisive leadership was balanced with open dialogue and collaboration within the team. As new problems arose, teams would dialogue and leadership would take swift action for the safety of the community. Additionally, teams had to exhibit humility, as what was best evidence one day could be contradicted the next. With that in mind, situational and humble leadership were key to the success of the telemedicine ad hoc teams.

CONCLUSION

Ad hoc teams make up a large cohort of medical teams,¹³ and telemedicine is growing exponentially. Thus, combining ad hoc team utilization with an innovative telemedicine response was logical and successful. Administration and team leaders navigated the challenges of a large response with ad hoc teams, proven communication techniques, and situational leadership. Studies exist for steady ongoing teams, but have been lacking for ad hoc teams. Although this is one success story, studies are needed to ascertain the optimal use of ad hoc teams—specifically how to create, train, manage, deploy, and lead them.

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